OMB Approved No. 2900-0149
Respondent Burden: 15 minutes

Department of Veterans Affairs

APPLICATION FOR CONVERSION
GOVERNMENT LIFE INSURANCE

PRIVACY ACT INFORMATION: No insurance may be converted unless a completed application form has been received (38 U.S.C. 1904 and 1942). The information provided on a voluntary basis, will be used by VA employees and your authorized representatives in the maintenance of Government Insurance programs. Responses may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U. S. Government Life Insurance Records - VA, published in the Federal Register.

RESPONDENT BURDEN: VA may not conduct or sponsor and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

IMPORTANT
Answer all items.
Do not return policy with this form.

1. INSURANCE FILE NUMBER (Include etter prefix)

2. FIRST, MIDDLE, LAST NAME OF INSURED AND MAILING ADDRESS FOR INSURANCE PURPOSES (Include number and street or rural route, city or P.O., State and ZIP Code).

3. POLICY NUMBER TO BE CONVERTED (Include letter prefix)

4. VA CLAIM NUMBER (If any)

5. SOCIAL SECURITY NUMBER

6. DAYTIME TELEPHONE NUMBER (Include Area Code)

7A. PERMANENT PLAN(S) APPLIED FOR

- ☐ ORDINARY LIFE
- ☐ 20 PAYMENT LIFE
- ☐ 30 PAYMENT LIFE
- ☐ 20 YEAR ENDOWMENT
- ☐ ENDOWMENT AT AGE 60
- ☐ ENDOWMENT AT AGE 65
- ☐ MODIFIED LIFE 65
- ☐ MODIFIED LIFE 70

7B. AMOUNT OF INSURANCE TO BE CONVERTED

$

7C. IF YOU ARE NOT CONVERTING THE ENTIRE POLICY, DO YOU WISH TO CONTINUE ANY TERM INSURANCE?

☐ YES ☐ NO (If "Yes", enter amount $_____

8. METHOD OF PREMIUM PAYMENT

A. DESIRED METHOD OF PAYMENT (Check one)

- ☐ DIRECT PAYMENT TO VA (If checked, complete Item 8B)
- ☐ MONTHLY DEDUCTION FROM VA PENSION OR COMPENSATION
- ☐ MONTHLY ALLOTMENT FROM RETIREMENT/ACTIVE SERVICE PAY
- ☐ VA MATIC (Automatic Checking Account deduction)

B. DESIRED METHOD FOR DIRECT PAYMENT OF FUTURE PREMIUMS (Check one)

- ☐ MONTHLY
- ☐ QUARTERLY
- ☐ SEMIANNUALLY
- ☐ ANNUALLY

9. TOTAL PAYMENT AMOUNT

A. AMOUNT OF FIRST PREMIUM	$
B. TOTAL DISABILITY INCOME PROVISION (If any)	$
C. TOTAL AMOUNT	$

10A. ARE YOU NOW DISABLED?

☐ YES ☐ NO (If "Yes", give name of disability and complete Items 10B and 10C) (If "No", go to Item 11)

10B. DATE LAST TREATED BY PHYSICIAN OR HOSPITAL (Include VA physician or hospital)

10C. DOES YOUR DISABILITY PREVENT YOU FROM WORKING?

☐ YES ☐ NO (If "Yes", explain fully)

11A. SIGNATURE OF APPLICANT (Application MUST be signed and dated in ink) (Do not print)

11B. DATE OF APPLICATION

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE, CALL US TOLL-FREE AT 1-800-669-8477.